FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0022889

Facility Name: FRANKFORT TERRACE

Address: 40 N. SMITH ST. (Number) FRANKFORT (City) 60423 (Zip Code)

County: WILL

Telephone Number: (847) 674-5795 **Fax #** (847) 674-5794

IDPA ID Number: 36-2883294

Date of Initial License for Current Owners: 10/01/76

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MORRIS ESFORMES
(Title) GENERAL PARTNER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	120	Intermediate (ICF)	120	43,920	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,920	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	38,526	2,648	681	41,855	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,526	2,648	681	41,855	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.30%

D. How many bed-hold days during this year were paid by Public Aid?
50 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/76

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	129,130	13,429	5,940	148,499		148,499		148,499			1
2	Food Purchase		153,035		153,035		153,035	(762)	152,273			2
3	Housekeeping	134,965	17,248		152,213		152,213		152,213			3
4	Laundry	56,582	20,316	766	77,664		77,664	116	77,780			4
5	Heat and Other Utilities			95,969	95,969		95,969	298	96,267			5
6	Maintenance	59,393	10,295	21,085	90,773		90,773	5,304	96,077			6
7	Other (specify):*			6,855	6,855		6,855	52	6,907			7
8	**TOTAL General Services**	380,070	214,323	130,615	725,008		725,008	5,008	730,016			8
	B. Health Care and Programs											
9	Medical Director			2,500	2,500		2,500		2,500			9
10	Nursing and Medical Records	996,150	40,574	9,643	1,046,367		1,046,367		1,046,367			10
10a	Therapy	59,609		3,022	62,631		62,631		62,631			10a
11	Activities	84,699	8,401	2,228	95,328		95,328		95,328			11
12	Social Services	27,044		2,295	29,339		29,339		29,339			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,167,502	48,975	19,688	1,236,165		1,236,165		1,236,165			16
	C. General Administration											
17	Administrative	96,250		209,500	305,750		305,750	(192,654)	113,096			17
18	Directors Fees											18
19	Professional Services			37,716	37,716		37,716	3,810	41,526			19
20	Dues, Fees, Subscriptions & Promotions			19,736	19,736		19,736	(4,449)	15,287			20
21	Clerical & General Office Expenses	102,953	10,706	99,372	213,031		213,031	(65,346)	147,685			21
22	Employee Benefits & Payroll Taxes			219,424	219,424		219,424		219,424			22
23	Inservice Training & Education			2,355	2,355		2,355	47	2,402			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			33,176	33,176		33,176	471	33,647			25
26	Insurance-Prop.Liab.Malpractice			52,075	52,075		52,075	372	52,447			26
27	Other (specify):*							3,618	3,618			27
28	**TOTAL General Administration**	199,203	10,706	673,354	883,263		883,263	(254,131)	629,132			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,746,775	274,004	823,657	2,844,436		2,844,436	(249,123)	2,595,313			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: FRANKFORT TERRACE **#0022889** **Report Period Beginning: 01/01/2004** **Ending: 12/31/2004**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	5,940	
	REPAIRS & MAINTENANCE		0	
			0	5,940
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		766	
			0	766
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		32,438	
	ELECTRICITY		31,082	
	WATER		32,036	
	CABLE TV - LOBBY		413	
			0	95,969
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		6,360	
	PAINTING & DECORATING		469	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		9,534	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		1,306	
	FIRE SERVICE		3,416	
			0	
			0	
			0	21,085
7	**OTHER**			
	SCAVENGER		5,056	
	SECURITY SERVICE		1,799	6,855
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	2,500	2,500

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	548	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	4,920	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	NURSING PROGRAM CONSULTANT	XVIII B 38-2	1,050	
	DENTAL	XVIII B 38-2	3,125	
			0	9,643
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	2,818	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	204	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	3,022
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,228	
			0	2,228
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	2,295	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	2,295
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number FRANKFORT TERRACE **#0022889** **Report Period Beginning: 01/01/2004** **Ending: 12/31/2004**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	209,500	209,500
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	12,840	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	24,876	
			0	37,716
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	265	
	EMPLOYEE WANT ADS	XIX F	3,292	
	CONTRIBUTIONS	VI 20 XIX F	500	
	DUES & SUBSCRIPTIONS	XIX F	3,666	
	LICENSES & PERMITS	XIX F	7,672	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	1,386	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	2,955	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	19,736
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		250	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		66,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	18	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		12,284	
	MESSENGER SERVICE		0	
	STAFF DEVELOPMENT		20,820	99,372

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	131,942	
	UNEMPLOYMENT COMPENSATION	XIX D	19,128	
	WORKERS COMPENSATION INSURANCI	XIX D	49,349	
	HOSPITALIZATION INSURANCE	XIX D	11,881	
	EMPLOYEE BENEFITS - OTHER	XIX D	300	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	6,824	
	CHICAGO HEAD TAX	XIX D	0	219,424
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		2,355	2,355
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		33,176	33,176
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		52,075	52,075
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER 823,657

Facility Name & ID Number FRANKFORT TERRACE #0022889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			38,261	38,261		38,261	(5,228)	33,033			30
31	Amortization of Pre-Op. & Org.			697	697		697		697			31
32	Interest			114,204	114,204		114,204	(46,891)	67,313			32
33	Real Estate Taxes			52,199	52,199		52,199	1,279	53,478			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			28,536	28,536		28,536	3,373	31,909			35
36	Other (specify):* OFFICE RENT			9,360	9,360		9,360	(9,360)				36
37	**TOTAL Ownership**			243,257	243,257		243,257	(56,827)	186,430			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,880	65,880		65,880		65,880			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			65,880	65,880		65,880		65,880			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,746,775	274,004	1,132,794	3,153,573		3,153,573	(305,950)	2,847,623			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(6,313)	30		9
10	Interest and Other Investment Income	(48,079)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(762)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(18)	21		18
19	Entertainment		20		19
20	Contributions	(3,455)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(699)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(265)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,386)	20		28
29	Other-Attach Schedule	(17,629)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (78,606)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(227,344)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (227,344)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (305,950)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

FRANKFORT TERRACE

ID# 0022889

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 3191	6	1
2	STAFF DEVELOPMENT	(20,820)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(17,629)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(762)	0	0	0	0	0	0	0	0	0	0	(762)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	116	0	0	0	0	0	0	0	0	116	4
5	Heat and Other Utilities	0	0	0	298	0	0	0	0	0	0	0	298	5
6	Maintenance	3,191	0	1,359	754	0	0	0	0	0	0	0	5,304	6
7	Other (specify):*	0	0	20	32	0	0	0	0	0	0	0	52	7
8	**TOTAL General Services**	2,429	0	1,495	1,084	0	0	0	0	0	0	0	5,008	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(197,150)	4,496	0	0	0	0	0	0	0	0	(192,654)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(699)	106	4,356	47	0	0	0	0	0	0	0	3,810	19
20	Fees, Subscriptions & Promotions	(5,106)	0	657	0	0	0	0	0	0	0	0	(4,449)	20
21	Clerical & General Office Expenses	(20,838)	5,162	(49,802)	132	0	0	0	0	0	0	0	(65,346)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	47	0	0	0	0	0	0	0	0	47	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	149	322	0	0	0	0	0	0	0	0	471	25
26	Insurance-Prop.Liab.Malpractice	0	0	215	157	0	0	0	0	0	0	0	372	26
27	Other (specify):*	0	713	2,905	0	0	0	0	0	0	0	0	3,618	27
28	**TOTAL General Administration**	(26,643)	(191,020)	(36,804)	336	0	0	0	0	0	0	0	(254,131)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(24,214)	(191,020)	(35,309)	1,420	0	0	0	0	0	0	0	(249,123)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(6,313)	0	172	913	0	0	0	0	0	0	0	(5,228)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(48,079)	0	0	1,188	0	0	0	0	0	0	0	(46,891)	32
33	Real Estate Taxes	0	0	0	1,279	0	0	0	0	0	0	0	1,279	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	431	2,852	90	0	0	0	0	0	0	0	3,373	35
36	Other (specify):*	0	0	0	(9,360)	0	0	0	0	0	0	0	(9,360)	36
37	**TOTAL Ownership**	(54,392)	431	3,024	(5,890)	0	0	0	0	0	0	0	(56,827)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(78,606)	(190,589)	(32,285)	(4,470)	0	0	0	0	0	0	0	(305,950)	45

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		EKS MANAGEMENT	LINCOLNWOOD	BOOKKEEPING
				EMI ENTERPRISES	LINCOLNWOOD	MGMT CONSULT
				IME REALTY	LINCOLNWOOD	HOME OFFICE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 206,000	EMI ENTERPRISES	100.00%	$	$ (206,000)	1
2	V								2
3	V	17	OFFICERS SALARY				8,850	8,850	3
4	V	19	ACCOUNTING FEES				106	106	4
5	V	21	OFFICE EXPENSE				5,162	5,162	5
6	V	25	TRANSPORTATION				149	149	6
7	V	26	INSURANCE						7
8	V	27	EMPLOYEE BENEFITS				713	713	8
9	V	35	AUTO LEASE				431	431	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 206,000			$ 15,411	$ * (190,589)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	BOOKKEEPING	$ 66,000	EKS MANAGEMENT	100.00%	$	$ (66,000)	15
16	V								16
17	V	4	HOUSEKEEPING SALARIES				116	116	17
18	V	6	PAINTERS SALARIES				1,359	1,359	18
19	V	7	SCAVENGER				20	20	19
20	V	17	CFO SALARY				4,496	4,496	20
21	V	19	PROFESSIONAL FEES				4,356	4,356	21
22	V	20	WANT ADS/BACKGR CKS				657	657	22
23	V	21	OFFICE EXPENSE				16,198	16,198	23
24	V	23	SEMINARS				47	47	24
25	V	24	IN-STATE LODGING/MEALS						25
26	V	25	TRANSPORTATION				322	322	26
27	V	26	INSURANCE				215	215	27
28	V	27	EMPLOYEE BENEFITS				2,905	2,905	28
29	V	30	DEPRECIATION				172	172	29
30	V	35	EQUIPMENT RENT				2,852	2,852	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 66,000			$ 33,715	$ * (32,285)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	36	OFFICE RENT	$ 9,360	IME REALTY	100.00%	$	$ (9,360)	15
16	V								16
17	V								17
18	V	5	UTILITIES				298	298	18
19	V	6	REPAIR & MAINTENANCE				754	754	19
20	V	7	ALARM SERVICE				32	32	20
21	V	19	PROFESSIONAL FEES				47	47	21
22	V	21	OFFICE EXPENSE				132	132	22
23	V	26	INSURANCE				157	157	23
24	V	30	DEPRECIATION				913	913	24
25	V	32	INTEREST				1,188	1,188	25
26	V	33	RE TAX				1,279	1,279	26
27	V	35	STORAGE FEES				90	90	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 9,360			$ 4,890	$ * (4,470)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	BERNARD COHEN	GENERAL PARTN	ADMINISTRATION					MANAG. FEE	$ 1,500	17-3	1
2	MORRIS ESFORMES	GENERAL PARTN	ADMINISTRATION					SALARY	8,786	17-7	2
3	AVRUM WEINFELD	CFO						SALARY	4,496	17-7	3
4	PHILIP ESFORMES							MANAG. FEE	2,000	17-3	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 16,782		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EMI ENTERPRISES, INC
Street Address: 6865 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847)674-1946
Fax Number: (847)674-1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	OFFICERS SALARY	PATIENT DAYS	881,303	14	$ 185,000	$ 185,000	41,855	$ 8,786	1
2	19	ACCOUNTING FEES	PATIENT DAYS	881,303	14	2,230		41,855	106	2
3	21	OFFICE EXPENSE	PATIENT DAYS	881,303	14	107,899	87,197	41,855	5,124	3
4	25	TRANSPORTATION	PATIENT DAYS	881,303	14	3,109		41,855	148	4
5	26	INSURANCE	PATIENT DAYS	881,303	14	0		41,855	0	5
6	27	EMPLOYEE BENEFITS	PATIENT DAYS	881,303	14	14,871		41,855	706	6
7	35	AUTO LEASE	PATIENT DAYS	881,303	14	8,991		41,855	427	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 322,100	$ 272,197		$ 15,297	25

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EKS MANAGEMENT
Street Address: 6865 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847)674-1946
Fax Number: (847)674-1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	4	HOUSEKEEPING SALARIES	PATIENT DAYS	881,303	14	$ 2,437	$ 2,437	41,855	$ 116	1
2	6	PAINTERS SALARIES	PATIENT DAYS	881,303	14	28,615	28,615	41,855	1,359	2
3	7	SCAVENGER	PATIENT DAYS	881,303	14	429		41,855	20	3
4	17	CFO SALARY	PATIENT DAYS	881,303	14	94,671	94,671	41,855	4,496	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	881,303	14	91,723	65,670	41,855	4,356	5
6	20	WANT ADS/BACKGR CKS	PATIENT DAYS	881,303	14	13,841		41,855	657	6
7	21	OFFICE EXPENSE	PATIENT DAYS	881,303	14	341,059	251,740	41,855	16,198	7
8	23	SEMINARS	PATIENT DAYS	881,303	14	984		41,855	47	8
9	24	IN-STATE LOGING/MEALS	PATIENT DAYS	881,303	14			41,855		9
10	25	TRANSPORTATION	PATIENT DAYS	881,303	14	6,783		41,855	322	10
11	26	INSURANCE	PATIENT DAYS	881,303	14	4,521		41,855	215	11
12	27	EMPLOYEE BENEFITS	PATIENT DAYS	881,303	14	61,166		41,855	2,905	12
13	30	DEPRECIATION	PATIENT DAYS	881,303	14	3,617		41,855	172	13
14	35	EQUIPMENT RENT	PATIENT DAYS	881,303	14	60,061		41,855	2,852	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 709,907	$ 443,133		$ 33,715	25

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: IME REALTY CORP.
Street Address: 6865 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847)674-1946
Fax Number: (847)674-1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	RENTAL INCOME	312,263	16	$ 9,942	$	9,360	$ 298	1
2	6	REPAIR & MAINTENANCE	RENTAL INCOME	312,263	16	25,152		9,360	754	2
3	7	ALARM SERVICE	RENTAL INCOME	312,263	16	1,056		9,360	32	3
4	19	PROFESSIONAL FEES	RENTAL INCOME	312,263	16	1,575		9,360	47	4
5	21	OFFICE EXPENSE	RENTAL INCOME	312,263	16	4,388		9,360	132	5
6	26	INSURANCE	RENTAL INCOME	312,263	16	5,225		9,360	157	6
7	30	DEPRECIATION	RENTAL INCOME	312,263	16	30,446		9,360	913	7
8	32	INTEREST	RENTAL INCOME	312,263	16	39,619		9,360	1,188	8
9	33	RE TAX	RENTAL INCOME	312,263	16	42,669		9,360	1,279	9
10	35	STORAGE FEES	RENTAL INCOME	312,263	16	3,011		9,360	90	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 163,083	$		$ 4,890	25

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	LASALLE BANK		X	MORTGAGE		11/01/01	$ 2,218,297	$ 2,021,346			$ 113,577	1
2												2
3												3
4												4
5												5
	Working Capital											
6	LASALLE BANK		X	WORKING CAPITAL				118,000			627	6
7												7
8	RELATED PARTY	X									1,188	8
9	TOTAL Facility Related						$ 2,218,297	$ 2,139,346			$ 115,392	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,218,297	$ 2,139,346			$ 115,392	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 50,100	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 50,939	2
3. Under or (over) accrual (line 2 minus line 1).		$ 839	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 51,360	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 52,199	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	49,531	8
	2000	49,316	9
	2001	49,637	10
	2002	49,584	11
	2003	50,939	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME FRANKFORT TERRACE COUNTY WILL

FACILITY IDPH LICENSE NUMBER 0022889

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	19-09-21-410-007-0000	NURSING HOME	$ 3,509.20	$ 3,509.20
2.	19-09-21-410-021-0000	NURSING HOME	$ 47,429.80	$ 47,429.80
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 50,939.00	$ 50,939.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,373 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1976	$ 100,000	1
2					2
3	TOTALS			$ 100,000	3

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120		1976	1972	$ 1,233,000	$	25	$	$	$ 1,233,000	4
5											5
6											6
7											7
8	RELATED PARTY					877		877			8
	Improvement Type**										
9	BUILDING IMPROVEMENTS			1980	7,438		5			7,438	9
10	BUILDING IMPROVEMENTS			1981	3,000		15			3,000	10
11	BUILDING IMPROVEMENTS			1983	3,138		5			3,138	11
12	BUILDING IMPROVEMENTS			1987	8,474	269	31.5	269		4,696	12
13	BUILDING IMPROVEMENTS			1988	51,503	1,635	31.5	1,635		27,727	13
14	BUILDING IMPROVEMENTS			1988	13,056	414	31.5	414		6,802	14
15	BUILDING IMPROVEMENTS			1990	6,944	220	31.5	220		3,206	15
16	BUILDING IMPROVEMENTS			1992	21,890	695	31.5	695		8,644	16
17	BUILDING IMPROVEMENTS			1993	4,065	129	31.5	129		1,510	17
18	BUILDING IMPROVEMENTS			1993	24,826	636	39	636		7,148	18
19	BUILDING IMPROVEMENTS			1994	7,630	196	39	196		2,035	19
20	FLOORING			1995	4,350	112	39	112		1,087	20
21	ROOFING			1995	10,000	256	39	256		2,443	21
22	FLOORING			1995	1,712	44	39	44		412	22
23	ROOFING			1995	5,200	133	39	133		1,236	23
24	FLOORING			1995	14,193	364	39	364		3,291	24
25	PARKING LOT LIGHT			1996	5,700	380	15	380		3,230	25
26	ROOFING			1996	10,330	265	39	265		2,364	26
27	LANDSCAPE			1997	6,700	447	15	447		3,352	27
28	DOOR ALARM			1997	1,980	51	39	51		372	28
29	SHOWER			1997	1,660	42	39	42		304	29
30	TILE			1998	6,250	160	39	160		1,114	30
31	FLOORING			1998	2,650	68	39	68		468	31
32	AWNING			1999	3,530	235	15	235		1,293	32
33	FLOORING			1999	4,700	121	39	121		701	33
34	CARPET/COVE BASE			2000	11,042	986	20	552	(434)	2,247	34
35	ROOFTOP AC			2000	2,490	91	27.5	91		368	35
36	VERTICAL BLINDS			2001	974	122	20	49	(73)	196	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	CUBICLE CURTAINS	2001	$ 19,810	$ 2,474	20	$ 991	$ (1,483)	$ 3,964	37
38	ROOF REPAIR	2001	4,450	162	27.5	162		641	38
39	FLOOR TILE	2001	18,654	678	27.5	678		2,323	39
40	ROOFTOP HEAT COOL	2001	1,734	63	27.5	63		218	40
41	CARPET	2002	2,485	90	27.5	90		225	41
42	ROOF VENTILATOR	2002	1,155	42	27.5	42		105	42
43	WINDOW	2002	1,055	38	27.5	38		95	43
44	FENCE	2002	8,986	327	27.5	327		795	44
45	STEEL DOORS	2003	2,109	77	27.5	77		113	45
46	ROOFTOP AIR CONDITIONER	2003	2,068	75	27.5	75		109	46
47	FURNACES	2003	34,636	1,259	27.5	1,259		1,836	47
48	FLOOR VINYL TILES	2004	17,480	292	27.5	292		292	48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,593,047	$ 14,525		$ 12,535	$ (1,990)	$ 1,343,538	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 197,503	$ 13,040	$ 19,381	$ 6,341	10 YRS	$ 129,937	71
72	Current Year Purchases	18,177	11,573	909	(10,664)	10 YRS	909	72
73	Fully Depreciated Assets	347,886					347,886	73
74	RELATED PARTY		208	208			401	74
75	TOTALS	$ 563,566	$ 24,821	$ 20,498	$ (4,323)		$ 479,133	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,256,613	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 39,346	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 33,033	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (6,313)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,822,671	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 19,737 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	MAINT/ACTIVITY	03 FORD ECOLINE WAG	$ 683.65	$ 8,154	17
18	PAINTERS	03 CHEVROLET ASTRO VAN	645.00	645	18
19					19
20					20
21	TOTAL		$ #######	$ 8,799	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$ 0	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 71,427	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	888,479		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	73,013		6
7	Other Prepaid Expenses	53,269		7
8	Accounts Receivable (owners or related parties)	454,339		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,540,527	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	962,050		11
12	Long-Term Investments			12
13	Land	100,000		13
14	Buildings, at Historical Cost	1,233,000		14
15	Leasehold Improvements, at Historical Cost	360,047		15
16	Equipment, at Historical Cost	563,566		16
17	Accumulated Depreciation (book methods)	(1,900,628)		17
18	Deferred Charges	14,984		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,333,019	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,873,546	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 271,251	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	118,000		29
30	Accrued Salaries Payable	63,079		30
31	Accrued Taxes Payable (excluding real estate taxes)	23,718		31
32	Accrued Real Estate Taxes(Sch.IX-B)	51,360		32
33	Accrued Interest Payable	11,133		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 538,541	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,021,346		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,021,346	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,559,887	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 313,659	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,873,546	$	48

*(See instructions.)

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 319,475	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 319,475	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	336,298	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(342,114)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (5,816)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 313,659	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,448,390	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,448,390	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	48,079	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 48,079	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,496,469	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	725,008	31
32	Health Care	1,236,165	32
33	General Administration	883,263	33
	B. Capital Expense		
34	Ownership	243,257	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	65,880	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,153,573	40
41	**Income before Income Taxes (line 30 minus line 40)****	342,896	41
42	**Income Taxes**	(6,598)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 336,298	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,152	2,226	$ 56,368	$ 25.32	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,316	5,520	111,864	20.27	3
4	Licensed Practical Nurses	11,675	12,457	226,496	18.18	4
5	Nurse Aides & Orderlies	55,014	60,098	542,713	9.03	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,118	5,943	59,609	10.03	8
9	Activity Director					9
10	Activity Assistants	8,408	9,271	84,699	9.14	10
11	Social Service Workers	2,080	2,241	27,044	12.07	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,436	17,879	129,130	7.22	15
16	Dishwashers					16
17	Maintenance Workers	4,091	4,163	59,393	14.27	17
18	Housekeepers	15,052	17,069	134,965	7.91	18
19	Laundry	7,065	7,687	56,582	7.36	19
20	Administrator	2,080	2,328	96,250	41.34	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,561	12,475	102,953	8.25	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,186	2,356	18,653	7.92	31
32	Other Health C: MDS COORD	2,080	2,269	40,056	17.65	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	150,314	163,982	$ 1,746,775 *	$ 10.65	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 5,940	1-3	35
36	Medical Director	O	2,500	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	1,050	10-3	38
39	Pharmacist Consultant	H	4,920	10-3	39
40	Physical Therapy Consultant	L	2,818	10a-3	40
41	Occupational Therapy Consultant	Y	204	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	2,228	11-3	44
45	Social Service Consultant	E	2,295	12-3	45
46	Other(specify) DENTAL	S	3,125	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 25,080		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Nurse Aides	73	548	10-3	52
53	TOTAL (lines 50 - 52)	73	$ 548		53

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JUDITH MAJCHROWICZ	ADMIN		$ 96,250
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 96,250

B. Administrative - Other

Description	Amount
EMI ENTERPRISES	$ 206,000
BERNARD COHEN & ASSOC.	1,500
PHILIP ESFORMES	2,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 209,500
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ALPHA DATA	DATA PROCESSING	$ 3,593
HEALTH DATA SYSTEMS	DATA PROCESSING	1,004
LTC	DATA PROCESSING	1,320
MAXXSOURCE	DATA PROCESSING	1,464
NURSING CARE SYSTEMS	DATA PROCESSING	5,458
KRUPNICK BOKOR	ACCOUNTING	11,100
FREDERICK S. FRANKEL	LEGAL	165
HOLLAND & KNIGHT	LEGAL	7,274
SACHNOFF & WEAVER	LEGAL	2,254
STONE, MCGUIRE & BENJAMIN	LEGAL	2,773
WINSTON & STRAWN	LEGAL	216
PERSONNEL PLANNERS	UC CONSULTANT	1,095
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 37,716

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 49,349
Unemployment Compensation Insurance		19,128
FICA Taxes		131,942
Employee Health Insurance		11,881
Employee Meals		#REF!
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		300
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		6,824
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ #REF!

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 4,400
Advertising: Employee Recruitment	3,292
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	1,651
TRUST/FRANCHISE/CONTRIB/ETC	3,455
LICENSES & PERMITS	3,272
DUES & SUBSCRIPTIONS	3,666
MGMT CO ALLOCATION	657
TRUST/FRANCHISE/CONTRIB/ETC	(3,455)
Less: Public Relations Expense	(0)
Non-allowable advertising	(265)
Yellow page advertising	(1,386)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,287

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 0

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	PAINTING/DECORATIN	2001	$ 4,652	3YRS	$ 775	$ 1,551	$ 1,551	$ 775	$	$	$	$	$
2	PAINTING/DECORATIN	03/2003	7,249	3YRS			1,208	2,416	2,416	1,209			
3													
4													
5													
6													
7													
8													
9													
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12													
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14													
15													
16													
17													
18													
19													
20	TOTALS		$ 11,901		$ 775	$ 1,551	$ 2,759	$ 3,191	$ 2,416	$ 1,209	$	$	$

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL OF LONG TERM CARE $3,391**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **65,880**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **#REF!** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees